STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

RENEWAL APPLICATION PACKET
FOR COMPREHENSIVE CARE & EXTENDED CARE FACILITIES

*A renewal application packet must be submitted to the Long-Term Care unit **60 days prior** to the license expiration date of all comprehensive care and extended care facilities. The **complete** renewal application packet must be submitted to the Department to complete the renewal process. Please provide all required signatures and notary on the appropriate forms AND include your licensure fee based on the LONG-TERM CARE PROVIDER APPLICATION. Make checks payable to: Maryland Department of Health and Mental Hygiene. If you need additional information or have questions, please call 410-402-8201.*

A. Room and Bed Breakdown is required at the time of license renewal

B. Principal Physician Agreement & Relief Physician Agreement

C. Director of Nursing Agreement

D. Facility Ownership (Medicaid Application)[1]

E. State Affidavit

F. Workers' Compensation Law Questionnaire

G. Certificate of Compliance, as applicable

H. Adverse Legal Actions/Convictions

I. Chain Home Office Information

[1] If not a Medicaid provider, only submit the "Provider Ownership and Control Disclosure form"

SECTION A - LONG TERM CARE PROVIDER APPLICATION

APPLICANT INFORMATION E-mail_____ Fax_____

Name of Facility_____ Telephone No_____

Location_____
(Street)

_____
(City) (County) (Zip)

TYPE OF BUSINESS ORGANIZATION
□ Individual □ Partnership □ Corporation □ Association □ Other:_____

TYPE OF CONTROL □ Proprietary □ Voluntary Non-Profit: □ Church □ Other (Specify)_____
□ Government Unit: □ State □ City □ County

LEASING ARRANGEMENT (If an entity operates the business under a lease, the following section shall be completed):
Lessee Name(s) and Address(es)_____
Lessor Name(s) and Address(es)_____
Expiration Date of Lease _____

Applications on behalf of a corporation, association, government unit or agency shall be made by two officers of the corporation, association or governmental unit or agency and names and addresses of their board members shall be submitted.

Administrator_____ Administrator License No:_____

LONG TERM CARE FACILITY TYPE

□ Nursing Home Comprehensive Care Facility
□ Hospital Extended Care Facility
Number of Beds_____
□ Room & Bed breakdown attached

□ Does facility operate a special care unit?
□ YES: Type_____
Number of Beds_____
□ NO

The 2-year license fee of $_____ (see fee rates below) is to be attached to the application. **(Fee is not refundable).** Make check or money order payable to "Maryland State Department of Health and Mental Hygiene"
Fee: 1 – 50 beds, $3,000 51-99 beds, $5,000 100+beds, $7,000 Transitional care unit, $600

I/We_____
(Please Print)
certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a facility subject to the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted there under by the Secretary of Health and Mental Hygiene.

1. Signature of Applicant_____ **Title**_____

2. Signature of Applicant_____ **Title**_____

Sworn and subscribed to before me this _____day of _____, _____ a Notary Public for the State of Maryland.

My Commission expires _____ _____
Notary Public

SEND COMPLETED APPLICATION TO:

Office of Health Care Quality
Bland Bryant Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville MD 21228

FOR OFFICE USE ONLY

□ **Initial** **Date:**_____ **Amt PD:** _____
□**Renewal** **Ck#:** _____ **Coord Name:** _____
□ **Change of Ownership** **Registration #:**_____ **License#:**_____

DHMH 125A – Revised 3/16/2010

SECTION B – LONG TERM CARE PROVIDER APPLICATION

PRINCIPAL PHYSICIAN AGREEMENT

Name of Facility: _____ License #:_____

NOTE: ***The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as a Principal Physician and a qualified relief to cover periods when his or her services are not available.***

As Principal Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*

2. *As necessary, I will advise the administration as the suitability of residents to be admitted or retained in the facility.*

3. *I will provide medical direction and coordination of the facility's medical care.*

4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*

5. *I will participate in the development of patient care policies, at lease annually. I will participate in the review of policies to ascertain that the facility's operations are consistent with its written policies.*

6. *I will be responsible for the surveillance of employee's health program.*

_____ _____

Principal Physician (signature) *Date*

Principal Physician Information (please type of print)

Name:_____

(First) (Middle) (Last)

Medical License Number: _____

Address:_____

City:_____ State:_____ Zip code:_____

Telephone Number(s):_____

SECTION B – LONG TERM CARE PROVIDER APPLICATION

RELIEF PHYSICIAN AGREEMENT

Name of Facility: _____ License #:_____

NOTE: ***The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as a Principal Physician and a qualified relief to cover periods when his or her services are not available.***

As Relief Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*

2. *As necessary, I will advise the administration as the suitability of residents to be admitted or retained in the facility.*

3. *I will provide medical direction and coordination of the facility's medical care.*

4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*

5. *I will participate in the development of patient care policies, at lease annually. I will participate in the review of policies to ascertain that the facility's operations are consistent with its written policies.*

6. *I will be responsible for the surveillance of employee's health program.*

_____ _____

Relief Physician (signature) *Date*

Relief Physician Information (please type of print)

Name:_____

(First) (Middle) (Last)

Medical License Number: _____

Address:_____

City:_____ State:_____ Zip code:_____

Telephone Number(s):_____

SECTION C – LONG TERM CARE PROVIDER APPLICATION

DIRECTOR OF NURSING AGREEMENT

Name of Facility: _____ License #:_____

****

This is to certify that I, _____ am a
Name

A. **Registered Nurse,** registry number _____

B. **Licensed Practical Nurse,** Board of Nursing registry number_____

and employed as **Director Of Nursing** for the above-name facility and carry the supervisory responsibilities of this position as described in State Regulations 10.07.02 par. 12 C & G.

My agreement with the **Administrator** requires that I be on duty _____**days** per week and work a minimum of 40 hours per week.

_____ _____
Director of Nursing (signature) *Date*

****

The above statement is correct and in accordance with the conditions under which

_____ is employed by this facility.
(*Director of Nursing)*

_____ _____
Facility Administrator (signature) *Date of Agreement*

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION INSTRUCTIONS

Please fill in the requested information as completely as possible. The following form definitions are provided to help clarify the information requested. Should you have any questions please contact the Provider Enrollment Unit at 410-767-5340

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NOTE:
PLEASE ATTACH A COPY OF ALL REQUESTED DOCUMENTS

1) APPLICATION TYPE
Check the appropriate box. If the request is to change existing data, then you must also include your Medicaid Provider Number. If you have already rendered service please indicate a Requested Enrollment Begin Date. The Provider Enrollment Unit will backdate your application (3) months prior to its receipt date. The enrollment begin date for an approved application is based on the date the application is received in our office.

2) PROVIDER INFORMATION
If you have a business, such as a pharmacy or medical supply, or a professional group enter the company name or the corporate group name. All physicians and other individual practitioners should enter last name, first name, middle initial and professional title.

Enter the address telephone and fax number of your primary practice location, contact person name and their telephone number and the practice e-mail or website address. Enter a **"Y"** for Yes or a "**N"** for No if your office is handicap accessible.

Enter the appropriate two-digit code for the county of your business practice location address. A listing of the county codes is provided for your reference at the end of these instructions.

Enter the Federal Employer ID Number and/or Social Security Number of the individual, group or business to whom the Medicaid reimbursements will be made.

3) LICENSE/PERMIT INFORMATION
Enter your medical license number, beginning effective date and expiration date for your practice location in which you service Maryland Medicaid recipients. If out of state, attach a copy of the current license certificate. Enter your NABP number if applicable.

Enter your Drug Enforcement Agency number and attach a copy of your DEA certificate. If you do not have a DEA number, this box should be left blank.

Enter your pharmacy permit number, if applicable.

Medical laboratory providers, practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** the following:

Enter Clinical Laboratory Improvement Amendment (CLIA)#
Attach a copy of the CLIA certificate
Enter Maryland Laboratory Permit or Letter of Permit Exception #
Attach a copy of Maryland Laboratory Permit or Letter of Permit Exception #

Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland.

Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.

4) PRACTICE INFORMATION
Enter the appropriate two-digit code for your type of practice. If this does not apply, leave blank. For your reference, a listing of the practice codes is provided at the end of these instructions.
If you are applying as an HMO, enter FR to indicate the type of contract as Full Risk with Abortion or SL to indicate t he type of contract as Stop Loss without Abortion. In addition, please complete and sign the enclosed form DHMH 4126-G located at the end of the application. Otherwise, leave this blank.

5) SPECIALTY INFORMATION
Enter a "P" to designate the primary specialty. If multiple specialty codes are entered, then you must designate one specialty as the primary specialty.

Physicians, Dentists and Pharmacies MUST enter the appropriate three-digit code from the specialty code listing provided at the end of these instructions. Enter OTH is you have another specialty not listed. PLEASE SPECIFY.

Enter the date you were certified for your specialty in MMDDYY format.

Enter the number, up to six digits, that was provided to you when you were certified for the associated specialty.

6) SPECIALTY VERIFICATION
Please check the applicable statement and attach the required documentation.

7) GROUP MEMBERSHIP INFORMATION
If you are a MEMBER OF A GROUP PRACTICE, please enter the name, Maryland Medicaid provider number and membership effective date for the group. If you are a GROUP PRACTICE, please list the names of each professional practicing in your group and his/her Maryland Medicaid provider number and membership effective date. All practitioners in the group MUST be enrolled as a Maryland Medicaid provider.

8) MEDICARE INFORMATION
If you are participating in Medicare, please list the fiscal intermediaries with whom you are enrolled (i.e. Blue Cross of Maryland, Traveler's Group Hospital Insurance, etc) and enter the provider number each has assigned to you.

9) ALTERNATE ADDRESS INFORMATION
Enter the Pay-To-Address address, you want your Medicaid reimbursement checks mailed. If you leave this section blank, your checks will be mailed to the primary practice location entered on the first page of the application.

Enter the Correspondence Address you want all your Medicaid related correspondence and remittance advices mailed. If you leave this area blank, correspondence will be mailed to the primary practice location entered on the first page of the application. Also, please indicate if you would like to receive correspondence electronically. If yes, please include your e-mail address on the first page of the application.

10) OTHER PRACTICE INFORMATION
Please enter other locations where you service Maryland Medicaid recipients. Include all group addresses where you are currently practicing. Enter a "Y" for Yes or a "N" for No if your office is handicap accessible.

11) AUTHORIZATION
Please sign and date the application.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION INSTRUCTIONS

Please fill in the requested information as completely as possible. The following form definitions are provided to help clarify the information requested. Should you have any questions please contact the Provider Enrollment Unit at 410-767-5340

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MEDICAL CARE PROGRAM * PROVIDER APPLICATION

COUNTY CODES

01	Allegany	07	Cecil	13	Howard	19	Somerset	40	Washington, DC
02	Anne Arundel	08	Charles	14	Kent	20	Talbot	99	Other State
03	Baltimore County	09	Dorchester	15	Montgomery	21	Washington		
04	Calvert	10	Frederick	16	Prince George's	22	Wicomico		
05	Caroline	11	Garrett	17	Queen Annes	23	Worchester		
06	Carroll	12	Harford	18	St. Mary's	30	Baltimore City		

SPECIALTY CODES

PHYSICIAN SPECIALTY CODES

026	Allergy & Immunology
045	Anatomic & Clinical Pathology
046	Anatomic Pathology
041	Anesthesiology
031	Cardiovascular Disease
053	Child & Adolescent Psychiatry
047	Clinical Pathology
004	Colon & Rectal Surgery
032	Critical Care Medicine
060	Dermatological Immunology/Diagnostic & Laboratory Immunology
058	Dermatology
059	Dermatopathology
017	Diagnostic Lab Immunology
055	Diagnostic Radiology
043	Emergency Medicine
033	Endocrinology & Metabolism
029	Family Practice
034	Gastroenterology
028	General Practice
003	General Vascular Surgery
008	Gynecologic Oncology
035	Hematology
036	Infectious Disease
030	Internal Medicine
009	Maternal & Fetal Medicine
037	Medical Oncology
025	Neonatal – Perinatal Medicine
038	Nephrology
014	Neurological Surgery
050	Neurology
051	Neurology with Special Qualification in Child Neurology
044	Nuclear Medicine
057	Nuclear Radiology
007	Obstetrics & Gynecology
015	Ophthalmology
013	Orthopedic Surgery
183	Osteopath
012	Otolaryngology
186	Pathology
018	Pediatric Cardiology
019	Pediatric Critical Care Medicine
020	Pediatric Endocrinology
021	Pediatric Gastroenterology
022	Pediatric Hematology - Oncology
023	Pediatric Nephrology
024	Pediatric Pulmonology
002	Pediatric Surgery
016	Pediatrics
048	Physical Medicine & Rehabilitation
011	Plastic Surgery
052	Psychiatry
049	Public Health & General Preventive Medicine
039	Pulmonary Disease
056	Radiation Oncology
054	Radiology
010	Reproductive Endocrinology
040	Rheumatology
001	Surgery
005	Thoracic Surgery
006	Urology

DENTAL SPECIALTY CODES

113	Dental – Other
123	Endodontics
057	Nuclear Radiology
131	General Dentistry
181	Oral Surgery
182	Orthodontics
187	Pedodontics
188	Periodontics

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PHARMACY SPECIALTY CODES

147	Home IV Therapy
151	Hospital Outpatient Pharmacy
156	Institutional Pharmacy
168	Multi-Specialty Pharmacy
184	Other Pharmacy
202	Retail Chain Pharmacy
204	Retail Single Pharmacy

MEDICAL CARE PROGRAM * PROVIDER APPLICATION

PROVIDER TYPE CODES

AC	Acupuncture	51	EPSDT Therapeutic Intervention	23	Nurse Practitioner (Indiv. Or Group)
50	ADAA Certified Addictions Outpatient Prog.	52	EPSDT Therapeutic Nursery	24	Nurse Psychotherapist (Indiv. Or Group)
T1	Ambulance Services	HH	Halfway House (Substance Abuse)	25	Nursing Agency (Private Duty)
39	Ambulatory Surgical Center	70	HMO	57	Nursing Facility
75	Assisting Living Services Provider	40	Home and Community Based Services, Other	76	Nursing Home Waiver Provider
AT	Attendant Care Waiver	41	Home Health Agency	18	Occupational Therapist (Indiv. or Group)
19	Audiology Services Provider	71	Hospice Provider	63	Oxygen Services
80	Behavior Consultant Provider	01	Hospital, Acute	44	Personal Care Aide
81	Case Management	03	Hospital, Rehabilitation Acute	45	Personal Care Aide Agency
CC	Certified Professional Counselor	04	Hospital, Rehabilitation Chronic	46	Personal Care Aide Level 4 Agency
82	Children's Medical Services (CMS) Provider	05	Hospital, Chronic	47	Personal Care Monitor
13	Chiropractor	06	Hospital, Special Pediatric	RX	Pharmacy
30	Clinic, Abortion	07	Hospital, Special Psychiatric	16	Physical Therapist
31	Clinic, Children and Youth	55	Intermediate Care Facility – Addiction (ICF-A)	20	Physician
32	Clinic, Drug Abuse (Methadone)	56	Intermediate Care Facility for the Mentally Retarded (ICF-MR)	11	Podiatry
33	Clinic, Family Planning	64	Kidney Disease Program	15	Psychologist
34	Clinic, Federally Qualified Health Center	10	Laboratories, Medical	PR	Psychiatric Rehab. Service Facility
35	Clinic, Local Health Department	91	Local Education Agencies/Local Lead Agencies	53	Residential Service Agency/ Home Health Aide Provider
36	Clinic, Maryland Qualified Health Centers	72	MCO	88	Residential Treatment Center
37	Clinic, Rural Health	42	Medical Day Care, Adult	SB	School Based Health Center
38	Clinic, General	43	Medical Day Care, Children	93	Senior Center Plus
90	DDA Services Provider	CM	Mental Health Case Management Provider	SA	Services to Medically Complex Patients in Nursing Facilities
14	Dental	MC	Mental Health Clinic	94	Social Worker
84	Diabetes Education	27	Mental Health Group Provider (Psychotherapist, Social Worker, Nurse Psychotherapist)	17	Speech/Language Pathologist
60	Diagnostic Services, other	29	Mental Hygiene Administration Service	TC	Therapeutic Community
61	Dialysis Facilities	MT	Mobile Treatment	28	Therapy Group Provider (PT.OT. Speech)
85	Dietician/Nutritionists	21	Nurse Anesthetists (Indiv. Or Group)	12	Vision Care
62	DME/DMS	22	Nurse Midwife (Indiv. Or Group)		

TYPE OF PRACTICE CODES

35	Group Practice	99	Other
50	HMO	20	Pharmacy, single store
30	Individual Practice	21	Pharmacy, 2-10 stores
31	Individual Practice, L/P hospital only	22	Pharmacy, 11+ stores
32	Individual Practice, Emerg. Room only	23	Pharmacy, hospital based
33	Individual Practice, O/P or clinic only	24	Pharmacy, nursing home based
10	Nursing Home	25	Pharmacy, tax supported

MEDICAL CARE PROGRAM * PROVIDER APPLICATION

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION

1) APPLICATION TYPE:

☐ New Enrollment

☐ Existing Provider/Change Provider Number

I am applying as a…. Please check one:

Requested Enrollment Begin Date

☐ Group

☐ Individual/Practitioner – Solo Practitioner or Member of a Group (*Please circle type)*

☐ Facility/Institution/ Business/Agency (*Please circle type)*

2) PROVIDER INFORMATION

*Please refer to the instructions for the appropriate codes.

Group/Facility/Business/Agency Name			Fiscal Year End Date
Physician/Practitioner Last Name	First Name		Title
Contact Person Name and Telephone Number		E-mail/Website Address	
Primary Practice Address		Suite Number	Handicap Access
City	State		Zip Code
Telephone Number	Fax Number	*County Code	*Provider Type Code
Employer Identification Number	Name of EIN Owner		Social Security Number

3) LICENSE/PERMIT INFORMATION

License/Permit Type	State Issued	License/Permit Number	Issue Date	Expiration Date
Medical				
DEA				
MDLAB				
CLIA				
NABP				
Pharmacy				
Other				

8) MEDICARE INFORMATION

Name	Medicare Number

9) ALTERNATIVE ADDRESS INFORMATION

Pay to Address

Address

City	State	Zip Code

Correspondence Address

Address

City	State	Zip Code

Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available? ☐ YES ☐ NO

10) OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you service Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. *Please refer to the instructions for appropriate codes.

Practice Address #2	Suite Number	Handicap Access

City	State	Zip code

Telephone Number	* County Code	License Number_____ Expiration Date_____

Practice Address #2	Suite Number	Handicap Access

City	State	Zip Code

Telephone Number	*County Code	License Number _____ Expiration Date_____

4) PRACTICE INFORMATION

* Please refer to the instructions for appropriate codes.

* Type of Practice	*HMO Type Category
_____ _____	_____ _____

5) SPECIALITY INFORMATION

* Please refer to the instructions for the appropriate codes.

Primary/Secondary Specialty	*Specialty Code	Certification Date	Certification Number

6) SPECIALTY VERIFICATION

Please check the applicable statement and attach the required documentation. Pursuant to amendments to Physicians Services Regulations (COMAR 10.09.02), effective July 1. 1979, the Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the following criteria:

☐ I have been declared board certified by a member of the American Board of Medical Specialists and currently retain that status. A photocopy of my specialty board certificate is attached.

☐ I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate residency review committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited and the completion date of my residency.

☐ I have been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my specialty board certificate is attached.

☐ I have been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists. Verification from my specialty that I am board eligible is attached.

☐ I have completed a residency program in a foreign country. My qualifications and training are acceptable for admission in the examination system of the appropriate American Specialty Board. A letter of my specialty board verifying this is attached.

If your application is for a group or professional association, each physician in the group or association who wishes to be considered a specialist must submit the required verification.

7) GROUP MEMBERSHIP INFORMATION

Group Name	Provider Number	Begin Date

11) AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

Date_____ _____

Signature of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

_____

Print of Type Name of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

_____

Signature of Owner (in the case of a Pharmacy)

Please return completed application to: Systems and Operations Administration
Provider Enrollment
P.O. Box 17030
Baltimore, MD 21203

SECTION D - PROVIDER APPLICATION * PRACTITIONER AND GROUP ADDENDUM

PRACTITIONER

If you are participating in a group practice, do you also provide care to Maryland Medicaid recipients in your private practice and wish to be reimbursed directly by the State? (Your personal tax identification number must appear on this application)

☐ YES ☐ NO

GROUP

If your group is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties:

Name of Facility _____

Address _____

Title _____

Duties _____

Is your group salaried by the above institution? ☐ YES ☐ NO

If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as a pharmacy)? ☐ YES ☐ NO

If you are an O.D., are you practicing optometry exclusively? ☐ YES ☐ NO or optometry as well as preparing and dispensing eyeglasses (as an optician)? ☐ YES ☐ NO

Is your group operating a Local Health Department Clinic? ☐ YES ☐ NO

Is your group operating a Freestanding Clinic ☐ YES ☐ NO

NOTE: All practitioners in a group must be enrolled as Medical Care Program providers.

LABORATORY INFORMATION

Completion of this section is required by individual practitioners and groups. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying codes of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients? ☐ YES ☐ NO

Do you provide medical laboratory services for other than your own patients? ☐ YES ☐ NO

Do you receive specimens that are obtained from other sites located in Maryland? ☐ YES ☐ NO

All Maryland practitioners are required to have a Maryland Laboratory Permit or Letter of Exception Number (§Health General Article 17-202 and 17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

SECTION D - PROVIDER APPLICATION * INSTITUTION ADDENDUM

Your Fiscal Year End Date:

Bed Data

Service Type	Number of Beds
Intermediate Care (ICF)	
Acute Inpatient (INP)	
Skilled Nursing (SNF)	
Chronic Hospital (CHB)	
Mental Retardation (MR)	
Other (OTH)	

DIALYSIS FACILITIES

Medicare Provide Number _____

Attach a copy of letter with assigned Medicare Provider Number.

Attach a copy of the letter(s) from your intermediary showing all current composite rates.

Note: You will be paid ONLY for the rate(s) appearing in this/these letters(s) in addition to those services provided, but not included in the composite rate.

PORTABLE X-RAY AND OTHER DIAGNOSTIC SERVICES MUST SUPPLY THE FOLLOWING:

Maryland Medical Test Unit Permit No. _____

Do you intend to bill for portability? ☐ YES ☐ NO

Note: All portable x-ray and other diagnostic service providers located within Maryland or serving patients located within Maryland MUST have a Maryland Test Unit Permit. The only out-of-state portable x-ray and other diagnostic services providers that do not have to have a Maryland Medical Test Unit Permit are those that serve Maryland Medicaid recipients in the State in which the provider is located and they must provide a Medicare number.

LABORATORY INFORMATION

Completion of this section is required. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients? ☐ YES ☐ NO

Do you provide medical laboratory services for other than your own patients? ☐ YES ☐ NO

Do you receive specimens that are obtained from other sites located in Maryland? ☐ YES ☐ NO

All Maryland practitioners are required to have a Maryland Laboratory Permit or Letter of Exception Number (§Health General Article 17-202 and 17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

PLEASE COMPLETE FORM DHMH 4126-G, PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM, AND SUBMIT WITH PROVIDER APPLICATION.

PLEASE COMPLETE FORM DHMH 4126-G, PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM, AND SUBMIT WITH PROVIDER APPLICATION.

SECTION D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

_____

Name of your Medical Service of Supply provider Ownership (as contained on your application

(Applicable to all Providers of items or services[i] except for individual practitioners or groups or practitioners[ii]

Pursuant to 42 CFR "455.100 et. Seq., the disclosure of the following is a required portion of the Maryland Medicaid Provider Application. Therefore, please answer the following questions and sign this document affirming that this information is true and complete, and return with your application. If necessary, please attach continuation sheets.

A. **NAME AND MAILING ADDRESS** of any person who, with respect to the Title XVIII and/orTitle XIX Provider[iii]:

1. is an officer or director

   _____

   _____

2. is a partner

   _____

   _____

3. has a direct or indirect ownership interest[iv] of 5% or more

   _____

   _____

4. has a combination of direct and indirect ownership interests equal to 5% or more in the Provider

   _____

   _____

5. is an owner (in whole or in part) of an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the Provider or its property or assets if that interest equals at least 5% of the value of the property or assets of the Provider

   _____

   _____

   _____

B. With respect to any subcontractor in which the title XIX Provider has, directly of indirectly, an ownership or control interest of 5% or more, name any person who falls within A. 1-5 above, as applied to the subcontractor and specify which of the above categories he falls within

   _____

   _____.

C. 1. If any person named in response to Part A. 1-5, above, has any of the relationships described in that Part with any Title XIX Provider of items or services other than the applicant, or with any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship.

   _____

   _____

   _____

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child or sibling.

   _____

   _____

SECTION D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services or the Maryland Department of Health and mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

A. the ownership of any subcontractor with which the title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000.00 and

B. any significant business transactions[v], occurring during the 5-year period ending on the date of such request, between the Provider and any wholly-owned supplier[vi] or any subcontractor.

C. the identity of any management company that will operate or contract with the applicant to operate the facility.

D. the ownership of equipment utilized for direct patient care.

_____ _____

AUTHORIZED SIGNATURE

_____

POSITION

---

[i] "Provider" or "provider" of services means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners.

[ii] "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

[iii] Identify any persons named, who are related to others named, as spouse, parent, child or sibling.

[iv] a. "Ownership Interest" means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

b. "Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

c. "Determination of ownership or control percentage"

1) Indirect ownership interest – The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in the corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest – In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, multiply the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

[v] " Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5 percent of the total operating expense of a provider.

[vi] "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of a hospital bed, or a pharmaceutical firm).

SECTION E – STATE AFFIDAVIT

Whoever knowing and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable State laws. In addition, knowing and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become licensed or, where the entity is already license, a revocation of that license.

I certify that the administrative and procedural requirements contained in COMAR 10.07.02 (Regulations governing Comprehensive Care Facilities and Extended Care Facilities) in the areas of written administrative and resident care policies, By-laws and other organizational documentation, written agreements with outside resources/consultants, committee meetings, staff qualifications and written development program such as inservices, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or if they have, I have notified the Office of Health Care Quality, in writing, before the effective date of the change. I further certify that I will notify the Office of Health Care Quality if there are any future "substantive changes in facility management and operation, " as defined in the instructions for completion of the Federal affidavit, that significantly affect policies and procedures and that notice will be given in writing before the effective date of the change.

NAME OF FACILITY:

_____

_____

Signature of Authorized Official **Title** **Date**

SECTION F –WORKERS' COMPENSATION LAW QUESTIONAIRE

Name of Facility

_____

(Please type or print)

Address of Facility

_____

(Please type or print)

Do you have Workers' Compensation Insurance for your employees?
(Check One) □ **YES** □ **NO**

If you have answered **YES** above; please provide the following information:

Policy Number: _____

Binder Number: _____

Insurance Company: _____

Effective Date: _____

Expiration Date: _____

If you have answered **NO,** please attach a copy of your Certificate of Compliance in accordance with State Workers' Compensation Laws.
(See attached form A52 and Instruction Sheet)

Please note
Your license cannot be issued unless this form is completed, signed, dated and provided to this Administration along with your "Certificate of Compliance" if applicable.

_____ _____

Signature Date

SECTION G – CERTIFICATE OF COMPLIANCE APPLICATION

INSTRUCTION SHEET

Please REVIEW INSTRUCTIONS BEFORE COMPLETING the Certificate of Compliance Application

The Workers' Compensation Commission will accept only the original application. (Do Not fax, photocopy or electronically reproduce) Type or print LEGIBLY or application may be returned without review. Complete the application in its entirety.

Line #1 Name of Company (If the company does not have a name leave blank)

Line # 2 Owner's Name (If corporation, list the name of the contact person)

Line # 3 Complete Business Address (P.O. Box is not acceptable)

Line # 4 Complete Mailing Address

Line # 5 Phone Number (Pager Number is not acceptable)
FEIN or Social Security Number is required. (If partnership, please Initial & list the last four digits of SS# for each partner. If using a FEIN#, SS #'s are not necessary.)

Line # 6 Check appropriate box (see back of application). Additionally, where indicated, please complete and attach Exclusion Form C-16R.

Line # 7 Sign and Date (If partnership, All partners must sign)

NOTE: Maryland Law § 9-201 requires an employer with one or more employees to carry workers' compensation insurance. Any employer with workers' compensation insurance is to submit proof (policy or binder number) of coverage to the Agency where they are applying for their license. DO NOT COMPLETE THE CERTIFICATE OF COMPLIANCE APPLICATION IF YOU HAVE INSURANCE COVERAGE. If you have any questions regarding the Certificate of Compliance, please call 410-864-5297 or 1-800-492-0479 and ask to be transferred to extension 5297. If you do not follow the aforementioned instructions, it may cause a delay in the processing of your application. Thank you for your cooperation.

CERTIFICATE OF COMPLIANCE

Before a governmental unit may issue a license or permit to a business for the purpose of engaging in an activity in which the business might employ a covered employee, the business shall submit to the governmental unit:

(1) a certificate of compliance with this title; or
(2) the number of a workers' compensation insurance policy or binder.

If a business is not covered by a workers' compensation insurance policy, an application to secure a Certificate of Compliance shall be submitted to the Workers' Compensation Commission pursuant to Labor & Employment Article §9-105. The sole purpose of a Certificate of Compliance is to identify those businesses which are not required to carry workers' compensation insurance coverage and to enable that business to apply for and obtain a license or permit from a government agency that requires proof of workers' compensation insurance coverage. A Certificate of Compliance is **not** workers' compensation insurance and is not binding on the Workers' Compensation Commission under any circumstance.

NOTE: Maryland Annotated Code LE §9-201 requires a business with one or more employees to carry workers' compensation insurance.

Eligibility: A business may secure a Certificate of Compliance in the name of the business, only if:

(a) the business is a sole proprietor with no employees;

(b) the business is a partnership with no employees other than the individual partners;

(c-f) the business is a Farm Corporation, a Maryland Close Corporation, a Professional Corporation or a Limited Liability Company with no employees other than corporate officers or limited liability company members who have elected, under §9-206, to be excluded from workers' compensation coverage;

(g) the business is an employer of only "casual employees" as provided under LE §9-205 and defined in Maryland Law; or

(h) the business is an owner operator of a Class F (Tractor) vehicle who meets the requirements of exclusion as defined under LE §9-218.

Mail Application to: The Workers' Compensation Commission
Attention: Certificate of Compliance Officer
10 East Baltimore Street • Baltimore, Maryland 21202-1641

Facsimile Applications Will Not Be Accepted. Do not photocopy or electronically reproduce.

SECTION G – CERTIFICATE OF COMPLIANCE APPLICATION

Licensing Agency's Stamp

APPLICATION FOR CERTIFICATE OF COMPLIANCE

(Please type or print legibly□Review instructions on reverse side prior to completing application)

1. _____
Name of Business (If trading as self, leave blank)

2. _____
Name of Owner(s) If a partnership, print each partner's name (attach separate sheet if necessary)

3. _____ _____ _____ _____
Business Address (P. O. Box Not Acceptable) City State Zip Code

4. _____ _____ _____ _____
Mailing Address City State Zip Code

5. (_____)_____ _____
Phone Number (Pager Number Not Acceptable) FEIN or Social Security Number(s)

6. The above named business would qualify for a Certificate of Compliance for the following reason: **(Check the appropriate box and do not modify or qualify the stated reasons in any way.)**

a. ☐ Sole Proprietor: The business is a sole proprietorship with no employees.
b. ☐ Partnership:The business is a partnership with no employees other than the individual partners.
c. ☐ A Maryland Close Corporation (attach Exclusion Form C-16R): The business is a Maryland Close Corporation with no employees other than corporate officers.
d. ☐ Farm Corporation (attach Exclusion Form C-16R): The business is a farm corporation with no employees other than corporate officers.
e. ☐ Professional Corporation (attach Exclusion Form C-16R): The business is a professional corporation with no employees other than corporate officers.
f. ☐ Limited Liability (attach Exclusion Form C-16R): The business is a limited liability company with no employees other than limited liability company members.
g. ☐ Casual Employees: The business only employs casual workers as provided in LE §9-205 and defined under Maryland Laws.
h. ☐ Owner/Operator of Class F Vehicle: The business is that of an owner operator of a Class F (Tractor) vehicle and meets the requirements of exclusion as defined under LE §9-218.

I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

7. _____ _____
Signature(s) **If a partnership, all partners must sign** (Use separate sheet if necessary) Date

After careful review of this application and based solely on the information contained in or attached to this application, the application is ☐ **APPROVED** ☐ **DISAPPROVED.**

_____ _____
Authorized Signature Date

An applicant who receives notice of disapproval may: (1) reapply for a certificate of compliance or (2) appeal the rejection in accordance with §§ 10-222 and 10-223 of the State Government Article.

Form A52 (Rev. 12/01/00)

WORKERS' COMPENSATION COMMISSION
10 East Baltimore Street
Baltimore, Maryland 21202-1641
TEL: (410) 864-5100 OR (1-800) 492-0479
TTY USERS CALL VIA MARYLAND RELAY

Date Stamp – WCC Use Only

EXCLUSION FORM

Pursuant to the provisions of Labor & Employment Article § 9-206 of the Annotated Code of Maryland, officers or members of a Farm Corporation, Close Corporation, Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor & Employment Article § 9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE: By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.**

DATE: _____ DATE COMPANY NOTIFIED INSURANCE COMPANY: _____

NAME OF CORPORATION'S INSURANCE COMPANY: _____

NAME OF COMPANY: _____

TYPE OF COMPANY: (Circle One) Farm Corporation, Close Corporation, Professional Corporation, Limited Liability Company

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Typewritten Name and Title of Officer or Member Electing Exclusion	% of Ownership	Personal Signature

IMPORTANT: Submit original form to the Workers' Compensation Commission, a copy to the insurer of the corporation, and keep a copy for your files.

FORM C-16R (Rev. 12/01/00)

SECTION I: ADVERSE ACTIONS/CONVICTIONS

This section captures information on adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

ADVERSE ACTIONS THAT MUST BE REPORTED

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal of State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connections with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal of State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under Federal of State law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under Federal of State law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation of suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION I: ADVERSE ACTIONS/CONVICTIONS (continued)

ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever has an adverse action listed on page 1 of Section I imposed against it?

   ☐ YES – Continue Below ☐ NO

2. If yes, report each adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.
   Attach a copy of the adverse action documentation and resolution.

Adverse Action	Date	Taken By	Resolution

SECTION J: CHAIN HOME OFFICE INFORMATION

This section captures information regarding chain organizations. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicaid fee-for-service contractor.

For more information on chain organizations, se 42 C.F.R. 421.404.

CHECK HERE ☐ IF SECTION J DOES NOT APPLY AND SKIP THIS SECTION

A. TYPE OF ACTION THIS PROVIDER IS REPORTING

Check one:	Effective Date	**Sections to Complete**
☐ Provider in chain is enrolling in Medicare for the first time (*Initial Enrollment of Change of Ownership*)	_____	Complete all of Section J.
☐ Provider is no longer associated with the chain organization previously reported	_____	Complete section J-C, identifying the former chain home office.
☐ Provider has changed form one chain to another	_____	Complete Section J in full to identify the new chain home office.
☐ The name of provider's chain home office is changing *(all other information remains the same).*	_____	Complete Section J-C.

B. CHAIN HOME OFFICE ADMINISTRATOR INFORMATION

Name of Home Office First Name	Middle Name	Last Name	Jr., Sr., etc.

Title of Home Office Administrator	Social Security Number	Date of Birth (*mm/dd/yyyy)*

C. CHAIN HOME OFFICE INFORMATION

1. Name of Home Office as Reported to the Internal Revenue Service

2. Home Office Business Street Address Line 1 (*Street Name and Number)*

Home Office Business Street Address Line 2 (*Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number (*if applicable)*	E-mail Address (*if applicable)*

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date (*mm/dd)*
4. Home Office Fee-For-Service Contractor	Home Office Chain Number

D. TYPE OF BUSINESS STRUCTURE OF THE CHAIN HOME OFFICE

Check one:

Voluntary:

- ☐ Non-Profit – Religious Organization
- ☐ Non-Profit – other *(Specify)*_____
- ☐ Proprietary
- ☐ Individual
- ☐ Corporation
- ☐ Partnership_____
- ☐ Other *(Specify)*_____

Government:

- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other *(Specify)*_____

E. PROVIDER'S AFFILIATION TO THE CHAIN HOME OFFICE

Check one:

- ☐ Joint Venture/Relationship
- ☐ Managed/Related
- ☐ Leased
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other *(Specify):*_____